**Vital Voices, a podcast from the Josiah Macy Jr. Foundation**
**Episode 6 Transcript**

*Holly Humphrey:*

*Welcome back to Vital Voices, a podcast from the Josiah Macy Jr. Foundation. I am Dr. Holly Humphrey, the president of the Macy Foundation. On today's episode, we will discuss an area of bias and discrimination within the healthcare system that remains a significant challenge; namely, the ageism and age-related inequities in healthcare delivery and outcomes, and, specifically, how can we use our health professions' education processes to shape a more equitable future?*

*The COVID-19 pandemic brought ageism into harsh light with proposals for age-based rationing as the solution to critical shortages of ventilators and ICU beds. But this problem has persisted for decades. In fact, a landmark study from over 20 years ago showed that healthcare professions were significantly more likely to withhold life sustaining treatment for older patients, even after controlling for prognosis, and patient preferences. Has anything changed?*

*To help us explore this important issue and how health professions' education can help address ageism, I am joined today by Dr. Terry Fulmer. Dr. Fulmer is the president of The John A. Hartford Foundation, which is dedicated to improving the care of older adults. Dr. Fulmer's vision at The John A. Hartford Foundation has catalyzed the Age-Friendly Health Systems social movement.*

*Before joining the foundation, she served as distinguished professor and dean of health sciences at Northeastern University. Dr. Fulmer is the first nurse to have served as the president of the Gerontological Society of America which, in 2019, awarded her the Donald P. Kent award for exemplifying the highest standards for professional leadership in the field of aging. Just last month, Dr. Fulmer was selected as one of four nurse leaders to be designated as living legends by the American Academy of Nursing, the highest honor awarded by the academy. Dr. Fulmer is a longstanding friend of the Josiah Macy Jr. Foundation as one of our distinguished board members.*

*You can find this podcast, as well as all of our webinars, the conference recommendations, and other resources on our website at macyfoundation.org. And now, here's my conversation with Dr. Fulmer.*

*Dr. Fulmer, thank you so much for being with us today.*

Terry Fulmer:

Thank you, Holly. It's an honor to be here with you and I want to thank the Macy Foundation for all it does to improve health by advancing the education, and training of health professionals.

*Holly Humphrey:*

*Well, thank you for that. I always look forward to conversations with you because I always learn a great deal. And I know today will be no exception.*

*We all know that the population is aging. Despite the fact that this is a shared human experience, negative biases against all older adults persist in our society and even in our health care system. These biases, as you well know, have been demonstrated on multiple occasions to create significant risks to older adults' health, and to their wellbeing.*

*So, can you describe for our listening audience, some of the ways in which biases manifest themselves in healthcare?*

Terry Fulmer:

I'm so glad you started with ageism, Holly, because, unfortunately, stereotypes, prejudice and discrimination based on age does happen frequently and it is a global phenomenon. So, the World Health Organization this year released its global report on ageism, and they noted that ageism is a neglected, but very important social determinant of health. And in their systematic review on the impacts of ageism in their commissioned work (that included 422 studies from 45 countries), they found in 96% of the studies that ageism was associated with worse outcomes in all health domains examined. That's shocking.

*Holly Humphrey:*

*That is shocking. That's really shocking.*

*So, one piece of that is that health professionals need to understand this, and they need to understand a lot more about this. I know from publications in the medical literature that there are as many distinctions between the healthcare needs of the average 40-year old and the average 80 to 90 year old as there are between a child and an adult. Yet, I also know from firsthand experience that medical students spend three times as much training in pediatrics compared with the time they spend in geriatrics. This is a problem, not only in medical schools, but I'm told that it's a problem in nursing as well with only 5% of registered nurses, and advanced practice nurses certified in geriatrics.*

*So, how do we change this paradigm? How do we move the needle across our health professions' education systems?*

Terry Fulmer:

Sure. Holly, what you're pointing out is ageism -- not only does it show up in undertreatment or overtreatment of older adults, but also in the way that role models for students approach their older adult patients. So, I think that your question, Holly is what do we do about that? And you touched on the notion that we have a shortage of geriatricians. And I will say that, in general, that there is a pay scale difference. If you are board certified in internal medicine, and then you get board certified in geriatrics your salary goes down. So, that's not much of an incentive.

Having said that, that is not the only reason because pediatricians are also at a different scale of payment versus anesthesiologists, dermatologists, etc. So, I think that prestige has a lot to do with it. And, again, this sort of apology for being a geriatrician is something I've seen over many years. I do think that we're seeing some change, but I'll know it's true change when I see a significant portion of curricula dedicated to caring for older adults and for the pathophysiology that's associated with aging that is not normal aging.

That's the other thing we see all the time is people attributing things to old age. And I'll give you the example of my Grandpa Frank. So, he was very active dairy farmer. He's no longer with us, but he was a very active dairy farmer. And Keith

and I went home to see him. And he was sitting, which is very unusual. And I said, "Grandpa Frank, what's up?" And he said, "Well, I've been a doctoring. And they told me that I'm just get getting older." And he said, "And they took some x-rays, but..." And I said, "Let me see the x-rays." In the x-ray he had such an obvious hip fracture it was stunning, honestly. And I said, "Grandpa, you have a hip fracture." He says, "You don't say?"

*Holly Humphrey:*

*Oh my goodness.*

Terry Fulmer:

I know. So, he gets the hip fracture fixed and he goes back to farming for another or 10 years. It was just classic. Just, "You poor dear, you're just getting old." That's something that is ageist, and bothersome, and you have to continuously watch for it in the clinical arena.

My last point is that if you were to listen to an exchange between clinicians and older adults, you'll very often hear the word, "Sweetie." I think we can do simulations around this with students where you're showing them worst practices and best practices. And the other thing you can do is record them and show them back what they're doing -- that's always shocking to students.

So, I think there's a lot of interesting strategies. Everybody wants their content in the curriculum, I understand that as somebody who used to be a dean, and so you have to have advocates as well, and there is a tendency for the advocates in aging and geriatrics to accept the status quo. And we just can't do that anymore.

*Holly Humphrey:*

*Yes. That's a powerful story about Grandpa Frank. So, good that Grandpa Frank has Dr. Terry Fulmer in the family to recognize that something was wrong!*

*But I'm also glad that you brought up the issue about salary discrepancies, and the fact that you do additional training, and actually know that your salary is likely to go down. However, I have also seen that when physician subspecialties are*

*compared, and they fill out satisfaction surveys it's the geriatricians who often turn out to be the happiest of all practicing physicians. What do you think is behind that?*

Terry Fulmer:

I think there's enormous satisfaction to the role that any of us in geriatrics have the great privilege to play in the lives of older persons. Many things, one of the things about geriatrics is the enormous complexity. You have people with 3 to 5 chronic diseases, or disorders, 5 to 10 medications with functional changes. And it's a huge jigsaw puzzle happening all the time and it's never stable, it is never stable. And so, to me, it's just fascinating to see how to do this work.

I was on a phone call earlier today with my friend, Dave Reuben from UCLA, an amazing geriatrician. And he and I often talk about the privilege of being able to work with older adults and listen to their stories. Talk about social determinants of health, some of our older adults today went through the Depression and they are still with us. And they went through a couple of world wars. Now, those groups are not going to be with us much longer, but when you look at the life experience and what they've needed to do to survive - through polio, for example, and they got their vaccines, didn't they?

*Holly Humphrey:*

*Yes, they did.*

Terry Fulmer:

Yes, they did. And they're still doing it. Older adults are more likely to get vaccinated than younger people. So, we see those data as well. So, I think enormous satisfaction, gratification, but I also think the complexity is fascinating.

*Holly Humphrey:*

*Yes. And you highlight the storytelling from which I think doctors, and nurses, and health professionals are inspired. And our aging population have the richest stories to teach us from.*

*The other thing that I observed as a dean for medical education is that our geriatric clinics were actually rich educational experiences for our students, and for our residents because it was in those clinics where our learners found interprofessional practice of medicine at its best, where nurses, and doctors, social workers, and geriatric psychiatrists, and so on and so forth really worked together as a collaborative, high-performing team in a way that was almost singular in their educational experiences.*

*But, despite all of these positives, we still know that 50% of the fellowship training positions in internal medicine and family medicine in geriatrics go unfilled every single year. And so, when the American Geriatric Society estimated that we need at least double the number of geriatricians by 2030, and you and I both know those fellowship training positions are only filling half as many positions as are available, we have a real problem.*

*Are there any other ways that you think health profession leaders can make a difference in this, now, very longstanding problem?*

Terry Fulmer:

Sure. I'm an incurable optimist, as you know, Holly, and I want to go back to one point you made about teaming. Geriatric interdisciplinary teaming is something that is really a wonderful thing to watch. And what you'll notice is that the clinicians and all team members move in and out of spaces, just almost it's like watching the evolution of a care plan because they move in and out of the spaces so seamlessly because they team so well together, and they really know each other's roles. And I want to point out that the Josiah Macy Jr. Foundation funded something called NYU3T, which is teaming, training and technology, which was a very powerful grant that ended up producing documents that are still in great use. Also, our foundation funded geriatric interdisciplinary team training, oh, about 30 years ago. And it was probably before its time and without technology, so technology has really made such a difference.

And I also want to point out the Geriatrics Workforce Enhancement program, which is funded by Health Resources and Services Administration, is doing a really

good job of making the field of geriatrics more appealing. And there are 48, what they call, "GWEPs" across the country and their goal is to educate and train workforce to care for older adults in integrated geriatric primary care models, and to partner with community-based organizations to address gaps in healthcare for older adults and promote Age-Friendly Health Systems, which I know we're going to talk about.

I do want to say that I think asking if we are going to have enough geriatricians is the wrong question. Let's say we do have enough geriatricians, and let's say they're super specialists, and that they are there in consultation with all of us in this country, just like a micro-hand surgeon, for example, how many are there?

*Holly Humphrey:*

*Not that many.*

Terry Fulmer:

Not that many.

So, I think it's the way that we spread and scale the knowledge and skills of geriatric science. And that's why we're so excited about the work we're doing now. So, I'm optimistic.

*Holly Humphrey:*

*That's terrific. And it is a perfect segue to something that I want to make sure we have a chance to talk about in today's episode. And it's one of the most exciting things that I believe you're doing. And that is the collaboration that The John A. Hartford Foundation has with the Institute for Healthcare Improvement to deliver age-friendly care in the United States.*

*So, what does this look like? And specifically I'd love to hear what those of us in health professions' education might be able to learn from what you and the IHI are doing.*

Terry Fulmer:

Thanks, Holly. One of my favorite topics. So, I always like to start by saying an Age-Friendly Health System starts at your kitchen table and should get you back to your kitchen table. It is the post-op care that you get. It's the care that you get at your local clinic. It's the care you get in your nursing home, or from your home attendant, or from your family member. And we like to say also that every older person deserves age-friendly care, and they should demand age-friendly care. So, we're spreading the Age-Friendly Health Systems movement, and it's a movement, and a way to spread geriatric competence among all clinicians.

I began my role at the foundation in 2015. And in 2016, we introduced the concept of age-friendly care with our partners at the Institute for Healthcare Improvement. And I will say that Don Berwick was front and center, even though he is emerita... Emeritus, excuse me, in that program. He's a senior advisor now. But we talked about it. It was just a magical moment because Don, he can make things happen. And so, I was speaking to Don, Derek Feeley was the then CEO of IHI, he was right on board. He had been a leader in healthcare in Scotland, where he felt like they needed to do a better job. And Kedar Mate, who has now followed Derek as the CEO of IHI. And Kedar's been with us since day one so what a gift. And Maureen Bisognano one of the other presidents of IHI is with us all the time. So, Don chairs, our advisory board, he is very serious about helping us move this.

And so, what are we talking about? Our aim is to get over the no do gap in healthcare. We have the evidence about what is most important to improve health outcomes for older adults, but we do don't reliably put it into practice. So, we worked with IHI experts in geriatrics and health system leaders to review the evidence, and distill it down to the essential vital few elements we call the 4 Ms and the 4 M's is a set, they cannot be parsed apart, they're a set of the following 4 M's: (1) what **matters** to the older individual, (2) **medication**, (3) **mentation**, and (4) **mobility**.

And we like to say that if you get those four things right, you will get exponentially the next dozen things right. So each of those M's represents an area in geriatric care that should be systematically addressed with evidence-based practices, which we have. And by creating that framework, we also have an initiative called

Action Communities, or Learning Networks. And we now have more than 2,400 hospitals, primary care practices, convenient care clinics and nursing homes using the 4M framework. That's the amazing capacity of IHI with their dissemination, and their systematic way of spread and scaling work.

And I also want to acknowledge my incredible partners at the American Hospital Association and the Catholic Health Association who have been partners with us right from that first year as well.

*Holly Humphrey:*

*Terry, that is a very exciting initiative that you just described so beautifully. You almost make me want to say, I'm looking forward to aging in America, given what you've just described, but-*

Terry Fulmer:

We've got you covered, Holly!

*Holly Humphrey:*

*That's terrific.*

*So, will this idea, and it's more than idea -- it's coming to in the very real ways that you just described, is this going to help us address the bias and discrimination that older adults continue to experience both in the healthcare system and beyond the healthcare system? So, I'm circling back to where we began this conversation. Will this help us get at the fundamental bias and discrimination?*

Terry Fulmer:

Yes. And why? Because it is evidence based, it's reliable. You get the triple aim, you get better care, better health, and lower costs. We have data to prove that. We have a number of papers that we have written on this already. And we have a special call, and *Health Services Research* is going to be doing a call for papers on the science of Age-Friendly Health Systems, which will be wonderful. And they'll go beyond that because we also were working with Age-Friendly Public Health

Systems through a wonderful organization called Trust for America's Health in Washington DC. So, that group has helped us spark a tremendous amount of enthusiasm in public health and what we call our triple A's: the Area Agencies on Aging.

We started in Florida as a pilot. That seems like a good place to start, if you're trying to improve care for older adults. And we brought together in a convening, John Auerbach was there with me leading that, a group of public health experts, and aging experts. The entire day they said, "I had no idea you did that." Then the other side would say, "I had no idea you did that." It was wonderful. We had hoped to get 20% of the counties in Florida to join us. And we ended up getting about 60% of the counties to join us. And now all of them are. Not only that, but we've now moved to three more states and we have a list of 10 states lining up to do age-friendly, public health. So it's about a whole ecosystem, which I'll talk about in a minute.

But I think the other thing we have to do, and I'll go back to your point about ageism, Holly, is we have to counter it through our language. And we work with a group called Frameworks in Washington, DC. You may have seen some of the work, it's really quite extraordinary. It's an institute that does very deep research that has helped us develop recommendations on how the field of aging should talk about issues in a way that mitigate ageism. It does not help to have someone say, "There's a silver tsunami." You should X that out of every conversation because it leaves people with a sense of helplessness, like there's nothing they can do.

Instead, you say, "We have this third age dividend," that's how Linda Fried puts it, you know her well. A third age dividend, you have all this excess knowledge, skill and capacity that our society needs. It's the only growing resources on the planet. So, what we like to say is we really love the reframing work, and we recommend it to everybody.

I also did want to get back to your physician fellowship question if you'd like, Holly.

*Holly Humphrey:*

*Oh sure.*

Terry Fulmer:

Okay.

*Holly Humphrey:*

*I have spent most of my career thinking about this physician fellowship question, so I'm happy to jump back there.*

Terry Fulmer:

I will say that the median salary difference between a dermatologist and a geriatrician is about $150,000. That's serious money.

And I will tell you that if you take a look at who's getting paid what is looking right at us. And that has to do with valuing. It its a societal cultural value about older people versus younger people.

Jack Rowe used to say, "We wish we had a geriscope, because if you had a geriscope, you could charge for it." We're a very low tech, high intense, high touch field. Geriscope, that was funny. So, anyway, we don't have that and look at the way in which we pay for health services. I do think value-based care and bundled payments will go long way to try to help this issue. But it's persistent and when you bring that up, people change the subject.

*Holly Humphrey:*

*Yes actually, Terry you're touching on so many interesting big issues it feels like there are potentially follow-up podcasts on several of these issues because they each kind of deserve their own episode.*

*But I want to go back to something that you mentioned just a few moments ago, and really invite you to help us wrap things up today by hearing your vision for that age-friendly ecosystem.*

Terry Fulmer:

Oh, I'd love to do that. Thanks Holly, I'd love to.

The World Health Organization in 2006, coined the term age-friendly cities. And you may have heard of that.

*Holly Humphrey:*

*I have.*

Terry Fulmer:

And then they started with age-friendly communities. And what I said was there's no such thing as an age-friendly city or community, if you don't have an Age-Friendly Health System in it.

Having said that, what we want to ensure is that the moniker age-friendly is not a meaningless tagline. It has to be measurable. It has to be something that you can follow evidence. And so, we're working with a team in Boston at the Age-Friendly Institute, Tim Driver and Jody Shue. We had three, very exhausting meetings bringing together people from WHO, and people from AARP, and the Milken Institute, and lots of scholars and practitioners to say, what are the measures you believe constitute this work? And it's all on their website. And we think it's just a powerful way to do handoffs, because if you're using a 4M framework, or if you know your framework and you can hand it off to the next group, they can use it instead of what we often do, which is start over again.

*Holly Humphrey:*

*Yes. That's very interesting.*

Terry Fulmer:

And what they're going to do Holly, to wrap this up, is they're going to list every hospital in the country and name it as age-friendly or not based on the IHI criteria. And then, they're going to take every nursing home and do the same. And then, they already have done the cities. So, I think that people will get it an appreciation

and awareness for where their community is. And if you had your choice, you'd go to an age-friendly facility.

*Holly Humphrey:*

*Absolutely.*

*Terry, this is such important work. And I am personally so glad that you are leading us into our future because it's inspiring to hear what you have to say, it's thought provoking. And I cannot thank you enough for your willingness to share your time, experience, and real expertise with us today. So, thank you very much for being with us. And I will be back in touch because there are so many interesting things that you brought up today that I know I'd like to learn more about. Thank you.*

Terry Fulmer:

Holly, thank you so much for the opportunity. It's just a great privilege to be a part of this today.

*Holly Humphrey:*

*For more on today's discussion, I encourage you to read the Macy Conference Recommendations and related resources. You can find all of these on the Macy Foundation website at macyfoundation.org.*

*Thank you for listening. And we hope you'll share this conversation with others. Be sure to subscribe wherever you get your podcasts, so you'll be notified when the next episode drops. And make sure you're signed up to receive email updates from the Macy Foundation. Thank you.*